

CHAPTER 1.1

Introduction

Mission Statement

It shall be the mission of the Division of Correctional Health Care Services (DCHCS) Dental Department to promote, stabilize, and maintain the oral health of all inmates incarcerated in the California Department of Corrections and Rehabilitation (CDCR). Dental services shall be provided to inmate/patients by competent professional healthcare staff who shall make every effort to provide quality dental services for the greatest number of inmate/patients within available resources. All dental services rendered shall be consistent with professional standards, and comply with all federal, state, and CDCR regulations.

Policy and Procedure Manual

This document is intended to serve as the approved model in the delivery of dental care, and in setting forth standards for the CDCR Dental Services.

The Standards and Scope of Services Policy for Dental Services outlined within this document represents the minimum requirements for the delivery of dental care and services within the CDCR. The term “medical” is used interchangeably with the term “all qualified health care personnel” through this document.

Each standard has been classified as either “essential” (E) or “important” (I). Essential (E) standards are, in general, more directly related to the health, safety, and welfare of prison inmates and the critical components of a health care delivery system. Important (I) standards are, in general, related to issues that strongly affect the delivery of health care and are significant but not critical. Whether essential or important, these standards may not be applicable in all situations.

It is expected that each institution shall apply these standards and policies and implement the described procedures in directing their dental services’ operation.

‡ This document shall be available in the offices of the Health Care Manager/Chief Medical Officer and the Chief Dentist at each institution.

Development and Annual Revision of Standards and Scope of Services

Development of the Dental Standards and Scope of Dental Services Policy incorporated input from other Health Services disciplines, (e.g., medical, pharmacy, mental health services) and since the delivery of quality health care is a dynamic process, it is expected that the Standards and Scope of Services Policy for Dental Services established by this document shall be subject to ongoing additions, deletions and changes. The dental policy and procedure manual shall be

reviewed annually and revised, as necessary, under the direction of the Chief Dentist, Dental Program, DCHCS. A committee of institutional dentists shall be established for the purpose of annually reviewing and updating this manual. Input from field operations is critical in the establishment of a current and dynamic dental standard of care; and comments and recommendations in reference to the standards are welcomed. Please forward all comments and recommendations to the Chief Dentist, Dental Program, DCHCS. Recommended changes made to specific policies in the manual must be dated, signed, and approved by the Chief Dentist, Dental Program, DCHCS prior to implementation. This process will allow all recommended changes made to be reviewed during the annual review.

Expectations of Dental Staff

In keeping with the CDCR policy regarding the Treatment of People, it is the expectation that all dental personnel shall adhere to the following behavior standards:

A. As concerns inmate-patients:

1. Regard each inmate-patient as an individual human being, to be treated with respect, impartiality, and dignity.
2. Consider the input of inmate-patients in the provision of their dental care.
3. Take time to explain dental procedures, policies, health care instructions, and methods of preventive dental care to each inmate-patient.
4. Recognize that each inmate-patient is constitutionally afforded a standard of dental care similar to that of the community at large.
5. Avoid personal bias in the performance of their duties.

B. As concerns all communications:

1. Strive to insure effective communications in the performance of their duties.
2. Support the goals and guidelines of ethical and conscientious health care practices.
3. Demonstrate integrity, respect, and compassion in both verbal and written communications.
4. Keep channels of communication open between management and staff to promote effective discussion.
5. Encourage, develop, and implement culturally sensitive communication with all staff members and inmates in order to improve the work place environment, and the quality of dental services.

C. As concerns the work environment:

1. Be responsible, reliable, and candid in responding to safety and security concerns, and remain aware at all times of their surroundings in the correctional environment.

2. Endeavor to provide all staff and all inmate patients with an environment that is safe, secure, and free of environmental hazard.
 3. Maintain professional decorum at all times.
- D. As concerns relations with co-workers:
1. Treat all staff with respect and dignity.
 2. Strive to create an apprehension-free environment, promoting teamwork, progress, and openness.
 3. Avoid personal bias in the performance of their duties.
- E. As concerns the pursuit of delivering quality dental care:
1. Strive to improve the quality of the dental health care delivery system.
 2. Be innovative in providing quality dental care under all conditions.

CHAPTER 1.2

Legal Considerations (I)

Federal law pertaining to an inmate's right to medical care has in recent years been well defined and clarified through case law. The legal standard governing inmates' rights to medical/health care is known as the "Deliberate Indifference" standard. This standard dates back to the 1976 *Estelle v. Gamble* Supreme Court case and established a legal precedent in the delivery of inmate's medical/health care. Both an objective factor and a subjective factor are evident in the court's final decision.

LEGAL PRECEDENTS:

Estelle v. Gamble

The 1976 case, *Estelle v. Gamble*, (429 U.S. 97 (1976)) remains one of the most important Supreme Court decisions pertaining to inmate-patient health care. In *Estelle v. Gamble*, an inmate seeking relief for inadequate medical treatment, had his case dismissed by the federal district judge. When the case reached the Supreme Court, however, the Court held that the Constitution's Eighth Amendment prohibition on "cruel and unusual punishment" applied to medical conditions. The court ruled that the Eighth Amendment placed substantive limitations on what punishment could be imposed on an inmate after sentencing and that this protection included a right to medical care in correctional institutions. Based on the standards of decency, the Court held that the government had an obligation to provide minimally adequate medical care in an appropriate setting to incarcerated inmates and that indifference to inmates' "serious medical needs" violates the Constitution of the United States.

Objective Component: Serious Medical Needs

In applying *Estelle v. Gamble* and other precedents, the federal courts have tried to define what constitutes a "serious medical need." In defining the term the courts stated:

- A serious medical need is one that has been diagnosed by a physician as requiring treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention. (*Hill v. Dekalb Regional Youth Detention Center*, 40 F.3d. 1176, 1186 (11th Cir 1994)).
- A condition is serious "if it is obvious to the layperson or supported by medical evidence" (*Simmons v. Coor*, 154 F.3d. 805, 807 (8th Cir. 1998)).

Courts have considered a number of factors in defining whether a medical need is serious, including:

- The effect of a delay in medical care.
- Whether the failure to treat could result in further significant injury or unnecessary and wanton infliction of pain.

- Whether a reasonable physician or patient would find the need important and worthy of treatment.
- The fact that a medical condition significantly affects daily activities.
- The existence of chronic and substantial pain.

(See *Hill*, 40 F.3d at 1186; *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992); *Gutierrez v. Peters*, 111 F.3d 1364 (7th Cir. 1997); and *Smith v. Jenkins*, 919 F.2d 90 (8th Cir. 1990)).

Specifically, courts have held that inmates have a right of access to timely medical care for their serious medical needs (*Toussaint v. McCarthy*, 801 F.2d 1080 (9th Cir. 1986)). With collateral application to delivery of dental care, courts have found additionally that treatment by unqualified staff, long delays in treating serious medical conditions, and denials of access to medical professionals are all actionable.

In finding that a medical need is “serious,” the Supreme Court held that an “unreasonable risk to future health” might justify relief even if no harm has yet occurred. Thus, basic communicable disease prevention measures and minimum sanitary standards are constitutionally required (*Helling*, 509 U.S. at 25). Courts have found that some chronic care conditions may also warrant special treatment, as delays in care that exacerbate an inmate’s existing medical condition may result in liability (*Chance v. Armstrong*, 153 F.3d 698 (2nd Cir. 1998)).

The Subjective Component of Deliberate Indifference:

In *Wilson v. Seiter* (501 U.S. 294 (1991)), the Supreme Court ruled decisively that a plaintiff must prove that a defendant had a culpable state of mind prior to any finding of liability (501 U.S. at 299-303). In *Farmer*, the Supreme Court further defined the intent standard and adopted a strict interpretation of “deliberate indifference” (511 U.S. at 836-642). The Court held that deliberate indifference requires proof that a defendant “knows of and disregards excessive risk to inmate health or safety” (511 U.S. at 837). The Courts noted that it is not enough to show that a defendant was aware of facts suggesting a risk existed. A plaintiff also needs to prove that the defendant actually drew the inference that those facts would expose inmates to such risk and still disregarded those facts.

As Justice Souter noted in his *Farmer* opinion, defendants are on dubious ground if they try to insulate themselves from knowledge of deficiencies in order to avoid a finding of deliberate indifference (511 U.S. at 842-844). If a systemic deficiency is truly obvious, a court may consider such obviousness as circumstantial evidence of actual knowledge about a constitutional deficiency. The fact that a defendant took steps to avoid learning about the problems may itself be an indicator of “deliberate indifference.” The *Farmer* decision also makes it clear that the knowledge requirement involved is not so specific that one must await a tragic event or show specifically who would have been harmed by a serious deficiency. It may be enough to show systemic problems likely to result in the type of harm addressed by a particular lawsuit, e.g., *Hunt v. Uphoff*, 190 F.3d 1220 (10th Cir. 1999).

CHAPTER 1.3

The Standard of Medical Autonomy (E)

I. POLICY

Clinical decisions and actions regarding health care services provided to inmates, in order to meet their serious medical needs, are the sole responsibility of qualified health care professionals.

II. PURPOSE

To define the standard of medical autonomy in order to ensure that clinical decisions are made solely for clinical purposes without interference from non-qualified personnel.

III. PROCEDURE

- A. The delivery of health care is a joint effort of administrators and health care providers and can be achieved only through mutual trust and cooperation. The health care authority, (i.e., the Health Care Manager, Chief Medical Officer, or designee), shall arrange for the availability of appropriate staff, equipment, and supplies, and for the monitoring of health care services to inmates. The official responsible for the facility, (i.e., the Warden or designee), shall provide the administrative support for the accessibility of health services to inmates and the physical resources deemed necessary for the delivery of health care.
- B. Qualified health care personnel include dentists, dental assistants, physicians, mental health professionals, nurses, medical technical assistants, and others who, by virtue of their education, credentials, and experience are permitted by law, within the scope of their professional practice, to evaluate and care for patients.
- C. Non-medical considerations, (i.e., inmates' access to care and the safety and security of the institution, etc.), needed to carry out clinical decisions, shall be made in cooperation with custodial staff. If this cooperation is lacking, the ability of health care providers to perform their professional and legal responsibilities is impaired and medical autonomy is jeopardized.
- D. Any specific problems that arise with medical autonomy generally shall be addressed through revised policies that shall be reviewed as part of the Continuous Quality Improvement (CQI) program.
- E. The following indicators shall be utilized to ensure that each facility is in compliance with the medical autonomy standard:
 - 1. All aspects of the standard shall be addressed by a written policy and defined procedures.

2. Clinical decisions and their implementation shall be completed in an effective, timely, and safe manner.
3. Custody staff shall support the implementation of clinical decisions.
4. Health care staff shall be subject to the same security regulations as other facility employees.

F. Definitions

- a. Custody staff refers to correctional officers, as well as correctional administrators.
- b. Health care staff refers to all qualified health care professionals, as well as health care administrative and support staff.

CHAPTER 1.4

Medical Autonomy (E)

I. POLICY

Each facility's Health Care Department, its agents, and the California Department of Corrections and Rehabilitation (CDCR) Division of Correctional Health Care Services (DCHCS) shall be responsible for providing, and overseeing health care to all inmates incarcerated in the CDCR. Decisions and actions regarding the health care services provided to inmates shall be the sole responsibility of qualified health care personnel and shall not be compromised except for security reasons, (i.e., as in situations in which an inmate's behavior or involvement in an incident may cause harm or injury to correctional or health care staff, him/herself, and/or other inmates).

II. PURPOSE

To identify the scope of responsibility and authority of each facility's Health Care Department, its agents, and the DCHCS.

III. PROCEDURE

- A. At the facility level, any security policies or practices that contradict direct medical orders shall be addressed by the responsible unit health authority/management team, (i.e., the Chief Dentist (CD) or designee, or the Health Care Manager (HCM) or designee), and the facility administrator, (i.e., the Warden or designee). If conflicts cannot be resolved at this level, the appropriate Regional Medical Director (RMD) shall be notified for resolution.
- B. At the facility level, the CD or designee and the facility administrator or designee shall address any security policies or practices that contradict direct dental orders. If conflicts cannot be resolved at this level, the HCM shall be notified for resolution.